Logic Model for Ontario's Chronic Disease Prevention and Management Framework

**Vision**
An integrated, coordinated system for the prevention and management of chronic diseases, with productive interactions and relationships among individuals/families, communities, and health care organizations/providers, that are proactive, individual and family-centred, and that provides access to quality care by the right provider at the right time in the right place

**Inputs**
Policy, Legislation/Regulations, Guidelines, Fiscal and Human Resources, Information Systems

**Components**
- Activated Communities and Prepared, Proactive Partners
- Informed, engaged individuals and families
- Prepared, proactive practice teams

**Outputs**
- Communities collaborating with HCOs to identify and prioritize issues affecting the health of the population.
- Communities championing activities for healthy public policy, and supportive environments.
- Community collaboration with HCOs to develop, link and coordinate services and information for individuals and families.
- Community information and programs integrated with health care services.
- Education, counselling, behaviour modification programs, and information for individuals and families to build skills for healthy living and coping with disease.
- Tools for individuals and families to become daily self-managers and communicate with providers.
- Care teams with individuals and families at the centre, and engaged in decision making and care planning.
- Self-management information and resources accessible and tailored to meet the needs of individuals and families.
- Community programs and resources integrated into care.
- Health promotion, primary, secondary, and tertiary prevention incorporated into care.
- Visible leadership, aligned incentives, policies, resources, measurement, and accountability for CDPM system changes.
- Interdisciplinary team practices, with links to specialists, where health care providers collaboratively provide patient-centred care in a seamless and coordinated manner.
- Integrated electronic information systems with comprehensive, accurate information for providers and individuals to share information & make the best decisions.
- Evidence-based tools for prevention, assessment and management incorporating planned interactions, and prompts for follow-up.

**Short-term outcomes**
- Increased community collaboration with HCOs to identify and prioritize issues affecting health.
- Increased community action for healthy public policy, supportive environments to meet the needs of their population.
- Increased awareness, linkages and referral to community programs, information, and resources.
- Individuals and families have increased skills and knowledge for healthy behaviours.
- Individuals, families and providers have improved understanding of their roles as partners on care teams, and consumers are involved in care planning.
- More individuals and families have increased knowledge of their disease processes and role as daily self-manager.
- Increased knowledge and skills of consumers in self-management.
- More individuals and families are aware of and linked to community programs and resources.
- Providers have increased knowledge, skills and tools to incorporate prevention into their practices.
- More HCOs promote system change and provide incentives, align policies, resources, measurement, and accountability.
- Increased number of interdisciplinary teams, with links to specialists working collaboratively and providing coordinated, patient-centred care.
- More providers using electronic information systems and sharing information among team members, their clients, other health providers and settings.
- More providers using evidence-based tools, and quality improvement approaches for prevention, assessment and management.

**Intermediate outcomes**
- Improved healthy public policies and supportive environments.
- More community information and programs integrated with health care services.
- More people exhibiting healthy behaviours.
- Individuals and families at the centre of the care team, actively engaged in decision-making, and daily managers of their health.
- More individuals and families gaining benefits through involvement in self-management.
- Increased participation in community programs and resources.
- Increased overall satisfaction of individuals and families with the responsiveness of the health care system to meet their needs.
- Health promotion and prevention integrated across continuum of care.
- Health care coordinated across the continuum of care, providers and settings.
- The appropriate type and number of health care providers working in collaboration to meet the needs of the individual and family.
- Care is evidence based and meets the diverse needs of consumers.
- Care is proactive, and provides for complex and continuing care, with follow-up and ease of navigation.
- Integrated information systems with consumer, decision support and community information.

**Long-term outcomes**
- Improved Clinical Outcomes
- Reduced burden of Chronic Disease
- Improved sustainability of the health system